STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445264	A. BUILDING _____ B. WING _____	11/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUGHLIN HEALTH CARE CENTER	801 E MCKEE ST GREENEVILLE, TN 37743

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F 000	INITIAL COMMENTS An annual Recertification survey and complaint investigation #28182 were completed on November 28-30, 2011, at Laughlin Health Care Center. No deficiencies were cited related to complaint investigation #28182 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	**Laughlin Healthcare Center acknowledges that during the Annual Recertification Survey and Complaint Investigation #28182, completed on November 28-30, 2011, no deficiencies were cited related to the complaint investigation #28182 under 42 CFR Part 483, Requirements for Long Term Care Facilities.**	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	**483.20(g) – (j) F 278 ASSESSMENT ACCURACY/COORDINATION/CERTIFIED** **REQUIREMENT:** The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000.00 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil Continue to page 2 of 7	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
B.B.A.	NURSING HOME ADMINISTRATOR	12.14.11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure accuracy of the Minimum Data Set (MDS) to identify hospice status for two residents (#5, #7) of eighteen residents reviewed. The findings included: Resident #5 was admitted to the facility on December 20, 2002, with diagnoses including Hypertension and Chronic Obstructive Pulmonary Disease. Medical record review of the Minimum Data Set (MDS) dated September 20, 2011, revealed the resident was not receiving any special treatments, procedures, or hospice care. Medical record review of the Hospice Plan of Care dated October 17, 2011, revealed the resident had received hospice services since December 21, 2010. Interview with the MDS Coordinator on November 29, 2011, at 2:48 p.m., in the MDS office, confirmed the MDS assessment failed to indicate the resident was receiving hospice services and was inaccurate. Resident #7 was re-admitted to the facility on October 22, 2010, with diagnoses including End Stage Dementia, History of a Cerebral Vascular Accident, and Stage 3 Kidney Disease.	F 278	Continued from page 1 of 7 money penalty of not more than $5,000.00 for each assessment. Clinical disagreement does not constitute a material and false statement. **POC:** 1. Residents #5 and #7 care plan has been updated on November 29, 2011 to reflect that both residents are receiving hospice care. 2. The MDS Coordinators working with the Inter-disciplinary Team will continue to revise, correct and update the residents care plan on a scheduled review cycle and as needed based on ongoing assessments. 3. The Inter-disciplinary Care Plan Team shall meet on at least a scheduled weekly basis and will systematically review MDS data and care plan approaches. The Utilization Committee will also meet at least weekly and will identify hospice residents during that meeting. 4. An 802 Report will be ran monthly under the supervision of the MDS Coordinators to identify all hospice residents. The facility Director of Nursing or designee with the help of the Inter-disciplinary Team shall observe for any discrepancies. **December 28, 2011**	

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F 278	Continued From page 2 Medical record review of the MDS dated November 9, 2011, revealed the resident was not receiving any special treatments or hospice care. Medical record review of a physician's order dated October 12, 2011, indicated the resident is receiving hospice care for End Stage Dementia. Interview with the Director of Nursing (DON) and the MDS Coordinator in the DON's office on November 30, 2011, at 8:10 a.m., confirmed the MDS was inaccurate and had not been updated to indicate the resident's hospice status.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety devices were in place for two residents (# 8, #13) of eighteen residents reviewed. The findings included: Resident #8 was admitted to the facility on July 21, 2011, with a history of falls, and diagnoses including Right Hip Fracture, Anemia, Arthritis,	F 323	**483.25(h) F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **REQUIREMENT:** The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. **POC:** 1. Resident #8 has been reassessed and a bed pad alarm placed on bed on November 29, 2011. 2. The Interdisciplinary Care Plan Team will continue to meet weekly to review and will systematically review residents that are care planned for alarms. Continue to page 4 of 7	

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F 323	Continued From page 3 Congestive Heart Failure, Dementia, and Hypertension. Medical record review of the Care Plan dated August 2, 2011, revealed the resident was assessed at risk for falls with care plan interventions including "...assist x1 (one staff member) and gait belt for transfers and ambulation...bed alarm on when in bed to alert staff to unassisted rising." Medical record review of a nurse's note dated November 17, 2011, at 5:40 a.m., revealed "...heard resident yelling for help. Upon entering room, resident noted lying on floor on right side..." Medical record review of a facility investigation dated November 17, 2011, revealed "...Bed alarm-not in use..." Interview with the Director of Nursing (DON) on November 29, 2011, at 1:30 p.m., in the DON's office, confirmed the facility failed to ensure the alarm was in place and checked by staff for placement and function. Resident #13 was admitted to the facility on March 10, 2011, with diagnoses including Muscle Weakness, Abnormality of Gait, and Macular Degeneration of the Left Eye. Medical record review of the Minimum Data Set (MDS) dated September 22, 2011, revealed the resident scored a two on the Brief Interview for Mental Status indicating severe cognitive impairment. Medical record review of the care plan dated	F 323	Continued from page 3 of 7 3. The Interdisciplinary Care Plan Team will provide an area on the CNA resident care record, where alarms are checked every 2 hours and as needed. 4. The RN Unit Managers along with the Interdisciplinary Team will review CNA resident care flow sheets to assure alarms are being monitored. **December 28, 2011** **POC:** 1. Resident #13 has both side-rails padded on November 30, 2011. 2. The RN Unit Managers along with the Interdisciplinary Care Plan Team will conduct a safety meeting at least weekly to review interventions put in place for incidents received during the past week. 3. The Interdisciplinary Care Plan Team shall continue to meet weekly and review resident care plans for accuracy. The Interdisciplinary Care Plan Team shall coordinate with the safety committee to ensure that interventions are in place. 4. The RN Supervisors, DON, and ADON will review interventions put in place to verify that correct interventions are in place. **December 28, 2011**	

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F 323	Continued From page 4 March 22, 2011, and updated on August 2, 2011, revealed "...bruise to r (right) calf-padding to siderail on r side of bed." Medical record review of a nurse's note dated August 2, 2011, revealed "...resident found (with) purplish bruise to r calf, skin surrounding bruise is reddened & (and) hard. Resident has been climbing OOB (out of bed) and observed (with) r leg under the siderail @ (at) times. Padding placed on siderail to prevent further pressure areas." Observations on November 29, 2011, at 2:44 p.m., November 30, 2011, at 7:53 a.m., and 9:03 a.m., in the resident's room, revealed the resident's bed had two siderails with no padding on either siderail. Observation and interview on November 30, 2011, at 8:58 a.m., with Certified Nursing Assistant (CNA) #1, in the resident's room, confirmed the resident's siderails were not padded and the CNA was unaware of the siderails ever having padding. Observation and interview on November 30, 2011, at 9:03 a.m., with the West Wing Unit Manager, in the resident's room, confirmed the resident was to have padded siderails to prevent injury and the siderails were not padded.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	**483.65 F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS** **REQUIREMENT:** The facility must establish and maintain an Infection Control Continue to page 6 of 7	

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F 441	Continued From page 5 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy, and interview, the facility failed to perform proper hand washing technique with dressing change for	F 441	Continued from page 5 of 7 Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it – (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions form direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Continue to page 7 of 7	

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F 441	Continued From page 6 one (#1) of eighteen sampled residents. The findings included: Resident #1 was re-admitted to the facility on October 24, 2011, with diagnoses including Pressure Ulcer, Diabetes, and Chronic Obstructive Pulmonary Disease. Observation of a dressing change on November 29, 2011, at 10:25 a.m., revealed the Licensed Practical Nurse (LPN) #1 removed the soiled dressing from the pressure ulcer, cleaned the pressure ulcer with normal saline, and removed the gloves. Observation revealed without washing the hands, the nurse applied new gloves and proceeded to complete the dressing change. Further observation revealed when the dressing change was completed, the nurse removed the gloves, placed them in the biohazard bag, and without washing the hands, picked up the biohazard bag, and took the bag down the hall to the biohazard room. The nurse then came back to the resident's room and washed the hands. Review of facility policy, Handwashing, revealed "...All facility personnel shall wash their hands in the following instances to prevent the spread of infections: Before applying and after removing gloves..." Interview with LPN #1 on November 29, 2011, at 11:30 a.m., in the East Nursing Station, confirmed the the facility's policy for handwashing was not followed during the dressing change.	F 441	Continued from page 6 of 7 **POC:** 1. Resident #1 involved in this incident. Treatment Nurse LPN was counseled with review of Policy and Procedure for this practice on November 29, 2011. 2. The facility's Annual In-service calendar lists infection control protocols including proper hand-washing. A mandatory hand-washing with return demonstration is conducted annually by hospital infection control staff. 3. An in-service for all licensed personnel directed towards hand-washing before and after use of gloves, will be completed before December 28, 2011. 4. The DON, ADON and Wing Managers will be responsible for direct observations to assure that licensed staff are performing hand-washing between glove changes. **December 28, 2011**	